



PA04-2002: WEIGHT REDUCTION REQUEST

RI MEDICAL ASSISTANCE PROGRAM
PRIOR AUTHORIZATION REQUEST FORM

FAX OR MAIL TO:
RI PA CALL CENTER
145 Technology Lane • Henderson, NC 27537
FAX # 1-800-390-0109

CLIENT NAME _____ DOB: _____ MEDICAID ID NUMBER: _____

PRESCRIBER NAME: _____ PRESCRIBER NPI #: _____

PRESCRIBER OFFICE ADDRESS: _____

OFFICE PHONE NUMBER : () _____

REQUESTER NAME: _____ RN /MD /R.Ph / _____

PHONE NUMBER: () _____ FAX NUMBER: () _____

DRUG REQUESTED : _____ QTY / FILL: _____

SPECIFIC CRITERIA IS AVAILABLE AT <http://www.dhs.state.ri.us/dhs/heacre/provsvc/mpharpa.htm> OR BY CALLING 1-800-390-0109

INDICATE THE RELEVANT DIAGNOSIS WITH APPROPRIATE ICD-9 CODE.

OBESITY ICD9 CODE :

Body Mass Index (BMI) _____ kg/m2

Client Weight _____

Client Height _____

EVIDENCE OF CO-MORBIDITY:

Diabetes Mellitus _____

Hypertension _____

Hyperlipidemia _____

APPROVAL OF REQUEST: _____

APPROVAL OF REQUEST: _____

INITIAL COVERAGE MONTHS 1 – 3 (3 MONTHS COVERED GRANTED)

CONTINUOUS COVERAGE MONTHS 4 – 6

EVIDENCE OF SUCCESS:

Weight at start of Treatment _____

Weight at end of 1st month _____

Weight at end of month 3 _____

(WEIGHT LOSS IN 1ST MONTH _____) MUST HAVE 4 LB. WEIGHT LOSS AT END OF 1ST MONTH

MUST MAINTAIN OR EXCEED 1ST MONTH WEIGHT LOSS AT THE END OF MONTH 3.

APPROVAL OF REQUEST: _____

CONTINUOUS COVERAGE MONTHS 7 – 11

EVIDENCE OF SUCCESS:

Weight at end of month 3 _____

Weight at end of month 6 _____

MUST MAINTAIN OR EXCEED WEIGHT LOSS AT THE END OF MONTH 3

MUST MAINTAIN OR EXCEED WEIGHT LOSS AT THE END OF MONTH 3

PREScriBER SIGNATURE _____ DATE _____

BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

RI PRIOR AUTHORIZATION CALL CENTER FAX NUMBER 1-800-390-0109 (AVAILABLE 24 HOURS)
RI PRIOR AUTHORIZATION CALL CENTER PHONE NUMBER 1-866-420-3874

RI PRIOR AUTHORIZATION - CALL CENTER HOURS
MONDAY – FRIDAY 9:00 AM – 6:00 PM (EST)

PA # _____ APPROVED _____ DENIED _____ PENDING ADDITIONAL INFORMATION _____
DATE /TIME OF RECEIPT _____ DATE/TIME RESPONSE _____ REVIEWER _____

COMMENTS: